Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN1502 | A. BUILDING _____ B. WING _____ | C 06/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEWPORT HEALTH AND REHABILITATION CE | 135 GENERATION DRIVE NEWPORT, TN 37821 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 002 | 1200-8-6 No Deficiencies<br><br>This Rule is not met as evidenced by:<br>A reassurance certification survey for Medicaid and complaint investigation #s 27250 and 28021, were conducted at Newport Health and Rehabilitation Center on June 13-15, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 002 | | |